Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Inpatient Hospital Services

Billing Instructions

October 2000

About this publication

This publication supersedes all previous Inpatient-Related Hospital Billing Instructions and Numbered Memorandum 00-40 MAA.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
October 2000

Related Billing Instructions

- Acute Physical Medicine & Rehabilitation (PM&R).
- Ground/Air Ambulance Transportation;
- Outpatient Hospital; and
- Physician-Related Services (RBRVS).

Notifying Clients of Their Rights (Advanced Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give all adult clients written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

Table of Contents

Table of Contents (cont.)

Important Contacts

Where do I call for information on becoming a DSHS provider?

Provider Enrollment Unit
(800) 562-6188 **Select Option 1** -or-
(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9246
Olympia WA 98507-9246

Magnetic Tapes/Floppy Disks:
Medical Assistance Administration
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I request copies of billing instructions?

Write, call, or see MAA's website
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188
http://maa.dshs.wa.gov,
Billing Instructions Link

How do I contact the Division of Health Services Quality Support (DHSQS) for information on, or to request…

Limitation Extension (LE) or Exception to Rule (ETR)?

Fax: (360) 586-2262
Telephone: (360) 725-1583
Or mail to:
Attn: LE Request or ETR Request
PO Box 45506
Olympia, WA 98504-5506

Acute PM&R Prior Authorization (Admission or Extension)?
Fax: (360) 586-2262

Length of Stay Extension (PAS)?
Mail to: Length of Stay Extension
PO Box 45506
Olympia, WA 98504-5506

Acute PM&R Authorization Number or Expedited Prior Authorization Inquiries?
(800) 634-1398 (1:00PM-4:45PM)

Extension Request for Hospitalization [DSHS 13-077(x)] forms may be obtained by writing to:

DSHS Warehouse
PO Box 45816 (Mailstop 45816)
Olympia WA 98504-5816
or fax your order to: (360) 664-0597

Please indicate the form number, title, number of forms desired, and a return address. The DSHS Warehouse does NOT accept telephone orders.

Important Contacts (cont.)

Where do I call if I have questions regarding..

Payments, denials, general questions regarding claims processing, Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic billing?

(360) 725-1267
or write to:
Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

Definitions

This section defines terms and acronyms used in this billing instruction. Please refer to MAA's General Information Booklet for other definitions.

Alcoholism & Drug Addiction Treatment & Support Act (ADATSA) - The law and a state-funded program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

Assignment - A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Authorization Requirement – MAA's requirement that a provider present proof of medical necessity evidenced either by obtaining a prior authorization number or by using the expedited authorization process to create an authorization number.

Authorization Number - A nine-digit number, assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Change of Ownership - Occurrence of the following events describes common forms of changes of ownership but is not intended to represent an exhaustive list of all possible situations:

1. A change in composition of partnership;
2. A sale of an unincorporated sole proprietorship;
3. The statutory merger or consolidation of two or more corporations;
4. Leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;
5. The transfer of a government-owned institution to a governmental entity or to a governmental corporation;
6. Donation of all or part of a provider's facility if the donation affects licensure, or certification of the provider entity;
7. A disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition, or abandonment if the disposition affects licensure, or certification of the provider entity.

Client – A person who received or is eligible to receive services through DSHS.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Coinsurance - The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is 20% of reasonable charges.

Community Services Office (CSO) - An office of the department which administers social and health services at the community level. (WAC 388-500-0005)

Contract Hospital – A hospital participating in MAA's hospital selective contracting program.

Cost Based Conversion Factor (CBCF) - A specific dollar amount that represents a hospital's average cost per DRG claim of treating MAA clients.

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medical Assistance program.

Day Outlier – A case that requires MAA to make additional payment to the disproportionate share hospital but does not qualify as a high-cost outlier. See "day outlier payment" and "day outlier threshold."

Day Outlier Payment – The additional amount paid to a disproportionate share hospital for the client five years of age or younger who has a prolonged inpatient stay exceeding the day outlier threshold, but whose covered charges for care fall short of the high cost outlier threshold. This amount is determined by multiplying the number of days in excess of the day outlier threshold multiplied by the administrative day rate.

Day Outlier Threshold – The average number of days a client stays in the hospital for an applicable DRG before being discharged, plus 20 days.

Deductible - The amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

Department - The state Department of Social and Health Services [DSHS]. (WAC 388-500-0005)

Diagnosis Related Group (DRG) – A classification system that categorizes hospital inpatients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases (ICD-9), the presence of a surgical procedure, patient age, presence or absence of significant complications or co-morbidities, and other relevant criteria.

Discharging Hospital - The institution releasing a client from the acute care hospital setting.

Distinct Unit – A Medicare-certified distinct area for psychiatric or rehabilitation services within an acute care hospital or a department-designated unit in a children's hospital.

DRG Exempt Services – Services that are paid for through other methodologies than those using cost-based conversion factor (CBCF) or negotiated conversion factors (NCF).

DRG Payment - A payment made by MAA for a client's inpatient hospital stay. This payment is calculated by multiplying the hospital-specific conversion factor by the DRG relative weight for the client's medical diagnosis.

DRG Relative Weight - The average cost of a certain DRG divided by the average cost for all cases in the entire database for all DRGs, expressed in comparison to a designated standard cost.

Emergency Services – Medical services required by and provided to a patient after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

For hospital reimbursement purposes, inpatient maternity services are treated as emergency services.

Exempt Hospital - A hospital that is either:

- Not located in a selective contracting area or is exempted by DSHS from the hospital selective contracting program; and/or
- Is reimbursed for services to MAA clients through methodologies other than those using cost-based or negotiated conversion factors.

Expedited prior authorization - The process of authorizing selected services in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

Expedited prior authorization number – An authorization number created by the provider that certifies that MAA published criteria for the service, supply, or equipment has been met.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) - A federal report generated by Medicare for its providers which displays transaction information regarding Medicare claims processing and payments.

Fixed Per Diem Rate - A daily amount used to determine payment for specific services.

Health Services & Quality Support, Division of (DHSQS) - The division within MAA responsible for promoting and improving the quality of health care consistent with community practice standards and including access, cost effectiveness, coordination and accountability to produce positive client outcomes.

High Cost Outlier - To qualify as a DRG high-cost outlier: **(A)** the allowed charges must exceed a threshold of three times the applicable DRG payment **or (B)** $28,000, whichever is greater. **For dates of service on and after January 1, 2001, (A)** the threshold will be three times the applicable DRG payment **or (B)** $33,000, whichever is greater.

Hospital - An entity which is licensed as an acute care hospital in accordance with applicable state laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

Hospital Covered Service – A service that is:

- provided by a hospital;
- included in the Medical Assistance program; and
- within the scope of the eligible client's medical care program.

ICD-9-CM (International Classification of Diseases, 9th Revision Clinical Modification Edition) – The systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alphanumerical designations (coding).

Inpatient Hospital Admission – An acute hospital stay for longer than 24 hours. To qualify for inpatient reimbursement, even when the stay is longer than 24 hours, the medical care record must evidence the need for inpatient care. MAA considers cases where the medical care record does not evidence the need for inpatient care to be outpatient short stays. In the following circumstances stays that are 24 hours or less are considered inpatient hospital admissions and paid as such:

- Death of the client;
- Obstetrical delivery;
- Initial care of a newborn; or
- Transfer to another acute care facility.

Inpatient Hospital – A hospital authorized by the Department of Health to provide inpatient services.

Length of Stay - The number of days of inpatient hospitalization (see also PAS Length of Stay).

Length of Stay Extension Request – A request from a hospital provider for MAA to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

Lifetime Reserve Days – The Medicare Part A benefit of 60 nonrenewable hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond the normal 90 day benefit period.

Low Cost Outlier - To qualify as a DRG low cost outlier, **(A)** the allowed charges must be less than or equal to ten percent of the applicable DRG payment **or (B)** $400.00, whichever is greater. **For dates of service on and after January 1, 2001, (A)** the allowed charges must be less than or equal to ten percent of the applicable DRG payment **or (B)** $450.00, whichever is greater.

Major Diagnostic Categories (MDC) – One of the 25 mutually exclusive groupings of principal diagnosis areas in the DRG system. The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) -The administration within the Department of Social and Health Services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medical Management Information System (MMIS) – The systems, structures, and program MAA uses to process medical claims.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts – Part A and Part B.

- **"Part A"** – that part of Medicare program that helps pay for inpatient hospital services, which may include, but are not limited to:

  - ✓ A semi-private room;
  - ✓ Meals;
  - ✓ Regular nursing services;
  - ✓ Operating room;
  - ✓ Special care units;
  - ✓ Drugs and medical supplies;
  - ✓ Laboratory services;
  - ✓ X-ray and other imaging services; and
  - ✓ Rehabilitation services.

Medical hospital insurance also helps pay for post-hospital skilled nursing facility care, some specified home health care, and hospice care for certain terminally ill beneficiaries.

- **"Part B"** does not apply to Inpatient Hospital Services.

Mental Health Division - The unit within the Department of Social and Health Services authorized to contract for, and monitor delivery of mental health programs. Also known as the State Mental Health Authority.

Negotiated Conversion Factor (NCF) – A negotiated hospital-specific dollar amount used in lieu of the cost based conversion (CBCF) factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital.

Noncontract Hospital - A licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the Selective Contracting Hospital Program.

Outliers – Cases with extraordinarily high or low costs when compared to other cases in the same DRG.

Out-of-State Hospitals - Any facility located outside the state of Washington or outside the designated border areas. The border areas are:

Oregon: Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles;
Idaho: Lewiston, Moscow, Priest River, Sandpoint, and Coeur d'Alene.

Outpatient Short Stay – An acute hospital stay of 24 hours or less with the exception of cases involving the following:

- Death of the client;
- Obstetrical delivery;
- Initial care of a newborn; or
- Transfer to another acute care facility.

When MAA determines that the stay does not meet the definition of inpatient hospital admission, even in stays longer than 24 hours, the stay is considered and reimbursed as an outpatient short stay.

Participating Hospitals – A DOH licensed hospital that accepts MAA clients.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and consists of:

a) First and middle initial (or a dash [-] must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters/characters of the last name (use spaces if the last name is fewer than five letters or use a hyphen for hypenated last names).
d) Alpha or numeric character (tiebreaker).

Per Diem – The daily charge per client that a facility may bill or is allowed to receive for its services.

Principal Diagnosis - The medical condition determined after study of the patient's medical records to be the principal cause of the patient's hospital stay.

Principal Procedure - A procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

Prior Authorization – Approval required from MAA before providing certain medically necessary services, items, or supplies. ***Expedited prior authorization and limitation extensions are forms of prior authorization.***

PAS (Professional Activity Study) Length of Stay - The average length of an inpatient hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled Length of Stay by Diagnosis, Western Region.

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department.

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Psychiatric Hospitals – Medicare certified distinct part psychiatric units, Medicare certified psychiatric hospitals, and state designated pediatric distinct part psychiatric units in acute care hospitals. State-owned psychiatric hospitals are excluded.

Ratio of Costs-to-Charges (RCC) - A method used to pay hospitals for services exempt from the DRG payment method. It also refers to a factor applied to a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services.

Regional Support Networks (RSN) - A county authority or group of county authorities recognized and certified by the department which enter into joint operating agreements to contract with the department pursuant to RCW 71.24 to operate a single managed system of services for persons with mental illness living in the service area covered by the county or groups of counties.

Remittance And Status Report (RA) - A report produced by the claims processing system in the MAA's Division of Program Support that provides detailed information concerning submitted claims and other financial transactions.

Revenue Code – A nationally-assigned 3-digit coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

Revised Code of Washington (RCW) - Washington State laws.

Room and Board – The services a hospital facility provides a patient during the patient's hospital stay. These services include, but are not limited to, a routine or special care hospital room and related furnishing, routine supplies, dietary and nursing services, and the use of certain hospital equipment and facilities.

Rural Hospital – A rural health care facility capable of providing or assuring availability of health services in a rural area.

Selective Contracting Area (SCA) - An area in which hospitals participate in negotiated bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by MAA patients.

Short Stay – See "Outpatient Short Stay."

Spenddown – The process of assigning excess income for the Medically Needy Program (MNP), or excess income and/or resources for the Medically Indigent Program (MIP), to the client's cost of medical care. The client must incur medical expenses equal to the excess income (spenddown) before medical care can be authorized. ***(This definition is for hospitals only.)***

Swing-Bed Days – A day in which an inpatient is receiving skilled nursing services in a swing-bed at the hospital's census hour. The hospital bed must be certified by HCFA for both acute care and nursing services.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Transfer – To move a client from one acute care facility or distinct unit to another acute care facility or distinct unit.

Trauma Care Facility – A facility certified by the Department of Health as a Level I, II, III, IV, or V facility.

UB-92 – The uniform billing document intended for use nationally by hospitals,

non-hospital based acute PM&R (Level B) nursing facilities, home health, and hospice agencies.

Usual & Customary Charge (UCC) - The charge customarily made to the general public for a procedure or service, or the rate charged other contractors for the service if the general public is not served. The UCC is the maximum amount that may be billed to the department for the service.

Washington Administrative Code (WAC) Codified rules of the state of Washington.

This is a blank page.

Reimbursement

Types of Reimbursement

The Medical Assistance Administration (MAA) reimburses for inpatient hospital services according to one of the following methodologies:

- Diagnosis Related Group (DRG) method; or
- Ratio of Costs-to-Charges (RCC) or Fixed Per Diem Rate method.

The primary payment method is the DRG method. Hospitals and services excluded from the DRG payment method are reimbursed with the RCC method. MAA applies a ratable factor to services for MIP, GAU, and ADATSA clients.

☞ **See next page for specifics**

Diagnosis Related Groups (DRGs)

(Primary Reimbursement Method)

DRG Reimbursement

MAA's Medicaid Management Information System (MMIS) determines the appropriate DRG grouping and pays accordingly. The primary payment method is based on the hospital's specific DRG conversion factor process.

DRG Conversion Factors

DRG conversion factors are either calculated or negotiated.

- If the DRG conversion factor is **calculated**, it is a cost-based conversion factor (CBCF).

  The factor is sometimes called the Formula Rate or DRG Rate. MAA establishes the payment by multiplying the hospital's cost-based conversion factor (CBCF) by the assigned DRG relative weight for that admission.

  Payment = Hospital's CBCF x Assigned DRG Relative Weight

- If the DRG conversion factor is **negotiated**, the hospital is part of MAA's hospital selective contracting (HSC) program.

  A negotiated conversion factor (NCF) is a contract rate established through MAA negotiation with a hospital-participating Medicaid inpatient selective contracting program. This NCF is sometimes called the Selective Contract Rate. The basic payment is established by multiplying the hospital's NCF by the assigned DRG relative weight for that admission.

  Payment = Hospital's NCF x Assigned DRG Relative Weight

Outliers

When a claim meets the criteria for an outlier payment (whether the DRG is calculated or negotiated), MAA adjusts payments as follows:

Low-Cost Outlier – To qualify as a DRG low cost outlier, **(A)** the allowed charges must be less than or equal to ten percent of the applicable DRG payment **or (B)** $400.00, whichever is greater. These cases are exempt from the DRG reimbursement methodology and are reimbursed under the RCC method. (See RCC section, page B.6.)

☞ **For dates of service on and after January 1, 2001, (A)** the allowed charges must be less than or equal to ten percent of the applicable DRG payment **or (B)** $450.00, whichever is greater.

High-Cost Outlier – To qualify as a DRG high-cost outlier: **(A)** the allowed charges must exceed a threshold of three times the applicable DRG payment **or (B)** $28,000, whichever is greater.

☞ **For dates of service on and after January 1, 2001, (A)** the threshold will be three times the applicable DRG payment **or (B)** $33,000, whichever is greater.

MAA determines reimbursement for high cost outlier cases using the applicable DRG payment plus a percent of the hospital's RCC rate applied to the allowed charges that exceed the high outlier threshold.

Calculating High-Cost Outlier Payment
(% of RCC x amount exceeding the outlier threshold) + DRG payment

Day Outliers - Day outlier claims are reimbursed by the applicable DRG Payment plus Administrative Day Payment. The administrative day rate is annually adjusted on November 1. The formula is:

Calculating Day Outlier Payment
(Outlier Days x Administrative Day Rate) + DRG payment

Miscellaneous DRGs

MAA may review miscellaneous DRGs for appropriate coding, medical necessity and appropriateness of place of service. Those procedures performed, incidental to the approved hospitalization and determined to be inappropriate for inpatient care, may be denied and the claim regrouped to a DRG that reflects the conditions related to the reason for hospitalization. If the DRG is converted to RCC payment, all Medicare rules for RCC payment are applied.

Transfers

Transfers are from one acute care facility or distinct unit to another acute care facility or distinct unit.

The following reimbursement guidelines apply when a client is transferred from one acute care facility or distinct unit to another.

A. When a hospital transfers a client to another acute care facility or distinct unit, MAA pays the transferring hospital a per diem rate when the patient status code 02 or 05 is used in form locator 22 on the UB-92 claim form.

The per diem rate is determined by dividing the number of days the client was in the hospital by that DRG's average length-of-stay. Payment to the transferring hospital will not exceed the DRG rate that would have been paid had the client been discharged. The hospital that ultimately discharges the client receives a full DRG payment. If a transfer case qualifies as an outlier, MAA will apply the outlier payment methodology.

B. When a client is admitted to Hospital A, transferred to Hospital B, then transferred back to Hospital A and is discharged, Hospital A is paid a full DRG as a discharging hospital. MAA does not reimburse Hospital A an additional per diem as the original transferring hospital. Hospital B is paid a per diem as described in A. above.

C. All nonemergent transfers require pretransfer approval. The transferring hospital must contact MAA's Division of Health Services Quality Support (DSHQS) and request a limitation extension (see page D.6), or in the case of psychiatric inpatient care, the appropriate RSN for an authorization number. MAA's authorization number must be noted in the client's records.

7-Day Readmissions

MAA's Division of Health Services Quality Support (DHSQS) reviews 7-day readmissions for clients who:

- Are admitted as an inpatient and discharged from a hospital; and
- Returns to the same hospital within 7 calendar days as an inpatient and the stay groups to the same major diagnostic category (MDC).

In the above circumstances, DHSQS reviews both the admission and readmission for payment. Admissions that MAA determines to be medically necessary and unavoidable will be paid both applicable DRG payments.

Examples of cases in which two separate DRG payments would not be allowed:

- ✓ Complication(s) from the first admission;
- ✓ A therapeutic admission following a diagnostic admission;
- ✓ A planned readmission following discharge; or
- ✓ A premature hospital discharge.

Note: This process does not apply to psychiatric admissions. All psychiatric admissions require authorization through the appropriate RSN.

Ratio of Costs-to-Charges (RCC)

Ratio of Costs-to-Charges (RCC) Reimbursement

MAA uses the RCC method to reimburse hospitals and services that are exempt from the DRG payment method. The RCC method is based on each hospital's specific RCC rate. RCC is calculated by multiplying the hospital's RCC rate by the allowable charges. The RCC methodology is not based on conversion factors or DRGs.

> ☞ **Note:** If a client is not eligible for the entire hospital stay, bill only the dates of service for which the client is eligible.

Low Cost Outliers: DRG stays that qualify as low cost outliers are paid by the RCC method. (See DRG Reimbursement, page B.3.)

Fixed Per Diem Rate Reimbursement

MAA uses the fixed per diem rate to reimburse for Acute Physical Medicine & Rehabilitation (PM&R).

Hospitals Reimbursed Under the RCC Method

(Non-DRG)

Non-DRG Hospitals

- **Military hospitals**
- **Out-of-state hospitals**
- **Peer Group "A" hospitals**
  Rural hospitals
- **Psychiatric hospitals**
  Including designated psychiatric facilities, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals

Services Reimbursed Under the RCC method

(Non-DRG services)

Acute Physical, Medicine & Rehabilitation Services (PM&R)	Provided in MAA-approved hospital Physical Medicine and Rehabilitation (PM&R). ***All Acute PM&R program admissions require prior authorization.***
Aids-Related Inpatient Services	Services provided in relation to: Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC) and other Human Immunodeficiency Virus (HIV) infections.
Alcoholism Treatment and Detoxification Services	Provided in DSHS-approved alcohol treatment centers.
Chemically-Using Pregnant (CUP) Women Services	Provided in DSHS-certified CUP hospitals.
Neonatal Services	DRGs 602-619, 621-628, 635, 637-641 **Note:** Normal newborns, DRG 620 and 629 are not identified as exempt; therefore are paid by the DRG conversion factor method, unless the facility is a Peer Group A hospital.
Organ Transplant Services	Bone Marrow Transplant (allogenic, autologous, syngeneic), Heart, Lung, Liver, Kidney, and Pancreas, Perpheral Stem Cell Transplant. Excludes experimental procedures. ***For extended stays (stays exceeding LOS), the RCC payment begins on the date of the transplant (see page C.12).***
Pain Treatment Services	Provided in MAA-approved pain treatment facilities.

Program Limitations

Medical Necessity

MAA will only reimburse for covered services and items that are medically necessary and the least costly, equally effective treatment for the client.

Administrative Days

Administrative days are those days of hospital stay where an acute inpatient level of care is no longer necessary, and an appropriate non-acute inpatient hospital placement is not available. Administrative days will be reimbursed at the statewide average skilled nursing facility (SNF) per diem rate.

- **For services reimbursed under the RCC method,** administrative days are identified during the length of stay review process.

- **For DRG services**, administrative day payments begin after the charges exceed the high-cost outlier threshold.

Hospitals are expected to justify admission and length of stay extensions that are administratively necessary.

Length of Stay (PAS)

All claims which are paid, exempt from DRGs, will be limited to the number of days established at the 75th percentile[1]. This does not apply to the following:

- Detoxification;
- Inpatient pain program;
- HIV/AIDS;
- Acute PM&R; and
- Neonate services (DRGs 602-619, 621-628, 635, 637-641).

Extension to Length of Stay - Providers must obtain an extension to the length of stay from MAA prior to billing. Complete the **Extension Request for Hospitalization** [DSHS form #13-077(x)] and attached at a minimum, the following:

- History and physical;
- Progress notes and doctor's orders for the entire length of stay; and
- Discharge summary.

In unusual cases, additional information may be requested in order for approval or denial of the extension request.

Send the Extension Request and Chart Information to:

Division of Health Services Quality Support
Quality Fee For Service Section – LOS Extension Request (PAS)
PO Box 45506
Olympia, WA 98504-5506

☞ **Note:** Any extension to stay in a psychiatric inpatient setting will require authorization by the client's Regional Support Network (RSN) of residence in order for payment to be made. An authorized extension request form for psychiatric hospitalization must be submitted with the UB-92 claim form. The RSN may require verbal information or written documentation in order to make a determination of approval or denial of the extension request. The appropriate extension request form for psychiatric hospitalization may be obtained from the RSN. This is a standardized form that has been imprinted with RSN identifying information.

Extension Request For Hospitalization [DSHS 13-077(x)] forms may be obtained by writing to:

[1] *Length of Stay By Diagnosis*, Western Region, current edition. Published by HCIA.

DSHS Warehouse
PO Box 45816 (Mailstop 45816)
Olympia, WA 98504-5816
or fax your order to: (360) 664-0597

Please indicate the form number, title, number of forms desired, and a return address.
The DSHS Warehouse does NOT accept telephone orders.

Outpatient Short Stay

MAA reimburses for stays of 24 hours or less as outpatient short stays, except in cases involving the following:

- Death of the client;
- Obstetrical delivery;
- Initial care of a newborn; or
- Transfer to another acute care facility.

Claims involving the above four scenarios must be billed as an inpatient admission.

When MAA determines that the stay does not meet the definition of inpatient hospital admission, even in stays longer than 24 hours, the stay is considered and reimbursed as an outpatient short stay.

Third-Party Liability

MAA reimburses hospitals for claims involving clients with third party-liability insurance:

- At the lesser of the DRG billed amount minus the third-party insurance payment amount or the DRG allowed amount minus the third-party payment amount; **or**
- The RCC allowed payment minus the third-party payment amount.

New Hospital Rate Guideline

New hospitals are those entities that do not have base year costs on which to calculate a rate. New hospital rates are calculated on the peer groups' average. **A change in ownership does not constitute the creation of a new hospital.**

Psychiatric Services

A transfer from one acute inpatient setting to another acute inpatient facility does not require a new certification of the need of care for the reason of transfer alone. The RSN shall provide prior authorization of the transfer to allow both inpatient facilities to bill for services provided as one service episode.

Remember! All claims with a psychiatric diagnosis must indicate whether the stay was voluntary or involuntary. The patient status at time of admission (voluntary, involuntary, or medical) is the status that should be indicated for the entire stay **(i.e., if patient is admitted as involuntary and then changes to voluntary, the entire stay is considered involuntary).**

Trauma Services

Budget and Legislative Background

- Effective with dates of service on or after July 1, 1996, the first major trauma enhancements began with additional compensation only for services provided by Designated Trauma Services to Medically Indigent Program (MIP) and General Assistance (GAU) clients and direct compensation to governmental trauma centers.

- **Major trauma patients** were originally defined as patients with an Injury Severity Score (ISS) or 16 or greater (95-97 biennium). This ISS was lowered to 9 or greater for the 97-current biennium.

- Effective with dates of service on or after January 1, 1999, major trauma services provided to any of MAA's fee-for-service clients at a Designated Trauma Center became eligible for enhanced reimbursement through the Trauma Services Fund.

Payment Limitations for Major Trauma

- To receive enhanced payment, the Department of Health (DOH) must identify the facility as a Designated Trauma Center. The facility's staff must maintain a quality improvement program and submit trauma registry data as prescribed by DOH. Verification of trauma service designation and patients' ISS will be done by DOH.

- Enhanced payments are limited to services provided by a member of a Designated Trauma Service Trauma Response Team to MAA clients who require major trauma services. These enhancements are for fee-for-service MAA clients only.

- Clients enrolled in a Healthy Options managed care plan have trauma payments included in their managed care rates. Hospitals have contracts with these managed care plans that may or may not include additional payments for various services such as major trauma.

Non-Designated Centers

- Hospitals not identified by DOH as Designated Trauma Services will continue to be reimbursed at the standard rates for Medical Assistance clients. A non-designated hospital that becomes designated must notify the Provider Enrollment Unit at PO Box 45562, Olympia, WA 98504-5562 of the change in status.

Governmental Designated Trauma Services (GDTS)

Governmental hospitals within Washington State receive grants instead of the enhanced hospital payments for each patient.

MAA has allocated a portion of these special funds for inpatient hospital services at these facilities as direct grant awards to governmental hospitals enrolled in the trauma network. These awards are based upon past and anticipated patient volumes and level of care provided. Funds are dependent on fees collected. These grants are separate from the participation grants awarded by DOH.

Payment Clarifications

These enhancements are for services performed during the initial hospitalization for inpatients at Designated Trauma Services Centers only. All hospital stays, including stays less than 24 hours, involving a transfer from one acute care facility or distinct unit to another acute care facility or distinct unit, must be billed as inpatient.

Note: Follow-up visits are often "bundled" into total inpatient charges. Follow-up services, if charged separately on outpatient claims, do not receive this enhancement.

Enhancements are determined at the end of the previously established payment-calculation process. Outlier claims will be enhanced at the end of the outlier payment calculation process (the entire payment, DRG and outlier portions, multiplied by the enhancement factor).

Billing

To identify clients eligible for enhanced payments, enter:

Claim Form	Occurrence Code	Where on claim?
UB-92	Occurrence Code **"X1"**	Form locator 32-35

For inpatient hospital charges, this occurrence code will be accepted only for the Designated Trauma Services listed under the non-governmental facilities (see page C.7 for list). DOH verifies the ISS values. Submit the required trauma registry data to DOH in a timely manner.

Note: Please do not interim bill inpatient trauma hospital claims.

Additional funds are available for treatment related to major trauma at Designated Trauma Services; however, you must use the proper code or modifier on the claim form to receive the enhanced payment.

For Additional Information

For information on **trauma service designation, trauma registry and/or injury severity scores (ISS),** contact:

Department of Health
Office of Emergency Medical & Trauma Prevention
(360) 705-6735 or (800) 458-5281

For information on **reimbursement**, contact:

MAA Medical Reimbursement Section
(360) 586-3743

For information on a specific **Medicaid trauma claim**, contact:

MAA, Provider Relations Unit
(800) 562-6188

DESIGNATED TRAUMA SERVICES

Non-governmental Facilities:
Auburn General (Auburn)
Cascade Medical (Leavenworth)
Central Washington (Wenatchee)
Darrington (Darrington)
Deaconess (Spokane)
Deer Park (Deer Park)
Emanual (Portland)
Good Samaritan (Puyallup)
Grays Harbor Community (Aberdeen)
Gritman Memorial (Moscow, Idaho)
Harrison Memorial (Bremerton)
Highline Community (Burien)
Holy Family (Spokane)
Inter-Island (Friday Harbor)
Kadlec (Richland)
Mary Bridge's (Tacoma)
Mt. Carmel (Colville)
Northwest (Seattle)
Our Lady of Lourdes (Pasco)
Overlake (Bellevue)
Providence (Centralia)
Providence (Everett - Colby)
Providence (Toppenish)
Providence-St. Peter's (Olympia)
Sacred Heart (Spokane)
St. Francis (Federal Way)
St. Johns (Longview)
St. Joseph (Bellingham)
St. Joseph (Chewelah)
St. Joseph (Lewiston)
St. Mary Med. Ctr. (Walla Walla)
Southwest Wash. (Vancouver)
Sunnyside Community (Sunnyside)
Tri-State Memorial (Clarkston)
Valley (Spokane)
Walla Walla General (Walla Walla)
Yakima Valley/Prov Yak Med (Yakima)

Governmental Facilities and their Trauma Service Level:

Level 1:
Harborview (Seattle)
Oregon Health Sciences University (Portland)

Level 2:
None

Level 3:
Island (Anacortes)
Kennewick General (Kennewick)
Skagit Valley (Mt. Vernon)
Valley Med. Ctr. (Renton)
Whidbey General (Coupeville)

Level 4:
Cascade Valley (Arlington)
Evergreen Hospital (Kirkland)
Forks Community (Forks)
Jefferson General (Pt. Townsend)
Kittitas Valley (Cle Elum)
Klickitat Valley (Goldendale)
Lake Chelan Community (Chelan)
Lewis Co. Hosp. Dist. #1 (Morton)
Lincoln (Davenport)
Mason General (Shelton)
Mid Valley (Omak)
Newport Comm. Hospital (Newport)
North Valley (Tonasket)
Ocean Beach (Ilwaco)
Okanogan-Douglas (Brewster)
Olympic Mem. Hospital (Port Angeles)
Othello Community (Othello)
Prosser Memorial (Prosser)
Pullman Memorial (Pullman)
Samaritan (Moses Lake)
Skyline (White Salmon)
Stevens Memorial (Edmonds)
Valley General (Monroe)
Willapa Harbor Hosp. (South Bend)

Level 5:
Columbia Basin (Ephrata)
Coulee Community (Grand Coulee)
Dayton General (Dayton)
East Adams Rural (Ritzville)
Ferry Co. Memorial (Republic)
Garfield County (Pomeroy)
Kittitas Hosp. Dist. #2 (Cle Elum)
Mark Reed (McCleary)
Odessa Memorial (Odessa)
Quincy Valley (Quincy)
Whitman County (Colfax)

*** Designated by Oregon only**

MAA-Approved Inpatient Pain Program

- MAA covers inpatient chronic pain management services only when the services are obtained through an MAA-approved chronic pain facility.

- A client qualifies for inpatient chronic pain management services when all of the following apply:

  - ✓ The client has had chronic pain for at least three months and has not improved with conservative treatment, including tests and therapies;
  - ✓ At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and
  - ✓ Clients with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs or alcohol for six months.

- For chronic pain management, MAA limits coverage to only one inpatient hospital stay per a client's lifetime, up to a maximum of 21 days.

- MAA reimburses for only the chronic pain management services and procedures that are listed in fee schedule.

- MAA will reimburse for inpatient pain services at the following facility:

MAA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma

☞ **Note:** MAA encourages any providers with a structured inpatient pain program that would like to be included as an MAA-approved facility to send their program criteria and credentials to:

Office of the Medical Director
PO Box 45506
Olympia WA 98504-5506

Inpatient Surgical Admissions

The following surgeries require expedited prior authorization (EPA), unless noted otherwise. See Section D – Authorization for expedited prior authorization criteria.

Current Selected Outpatient/Inpatient Surgeries	**ICD-9-CM Procedure Code(s)**	**Allowed Only for These ICD-9-CM Diagnosis Codes**
Reduction Mammoplasty **Mastectomy for Gynecomastia**	85.3 – 85.36	*611.1, *611.9 Hypertrophy of Breast or Gynecomastia
Hysterectomy for clients age 45 and under	68.3 – 68.7, and 68.9	
Note: ICD-9 diagnosis codes 179-184.9, 198.6 – Ovary; 198.82 – Genital Organs; 233.1-233.3 – Carcinoma in situ of cervix, uterus, or genital organs; 236.0-236.3 – Neoplasms of uncertain behavior of uterus, ovary or genital organs; 239.5 – cancer in other genital/urinary organs, **do not require authorization.**		
Laparoscopy with vaginal hysterectomy.	68.5, 68.7	
Note: ICD-9 diagnosis codes 179-184.9, 198.6 – Ovary; 198.82 – Genital Organs; 233.1-233.3 – Carcinoma in situ of cervix, uterus, or genital organs; 236.0-236.3 – Neoplasms of uncertain behavior of uterus, ovary or genital organs; 239.5 – cancer in other genital/urinary organs, **do not require authorization.**		
Bladder Repair	57.89 and 59.3 – 59.79	*625.6, *788.3

* **When there is a diagnosis code(s) in the 3rd column of the above table, the diagnosis code must be billed along with the identified ICD-9-CM procedure code in order to be reimbursed by MAA.**

Other Surgical Policies

The following surgeries are allowed **only** with the following diagnoses V10.3, 140-239.9, 757.6, 906.5-9, or 940-949.5. These are billable as inpatient admissions only when the stay meets the definition of inpatient admissions (see Definition section).

Description
Insertion of tissue expander(s)
Replacement of tissue expander w/permanent prosthesis
Removal of tissue expander(s) without insertion of prosthesis
Mastectomy, partial
with axillary lymphadenectomy
Mastectomy, simple, complete
Mastectomy, subcutaneous
Mastopexy
Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
Delayed insertion breasts prosthesis
Nipple/areola reconstruction
Breast reconstruction w/tissue expander
Breast reconstruction w/free flap
Breast reconstruction w/other technique
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
with microvascular anastomosis (super charging)
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
Open periprosthetic capsulotomy, breast
Periprosthetic capsulectomy, breast
Revision of reconstructed breast

Medical Admissions

Hospitals must use the expedited prior authorization process when the admission **and** principal diagnosis **both** appear below. See Section D – Authorization for expedited prior authorization criteria.

Description	ICD-9-CM Diagnosis Code(s)
Abdominal Pain	789.0-789.09
Back Pain	724.1-724.5, 724.8-724.9, 846.0-847.9
Cellulitis	681-681.9, 682, 682.2-682.9
Chronic pancreatitis	577.1
Constipation	560.3, 560.39, 564-564.9
Dehydration; Disorders of Electrolyte Imbalance	276-276.6, 276.8-276.9
Headache	784.0
Gastritis/Gastroenteritis	535-535.6, 558.9
Migraine Headache	346-346.9
Nausea/vomiting	536.2; 787.0-787.03
Malaise & Fatigue	780.7
Painful Respiration	786.52
Related general symptoms	780, 780.4, & 780.9
Respiratory abnormality	786.09

Children **(6 years of age and younger)**

Children, six years of age and younger, do not require authorization for hospitalization in a MAA contracted facility. Medical necessity must be documented in the client's record.

Out-of-State Hospital Admissions

Out-of-state hospital admissions are not covered unless they are emergency admissions associated with an MAA-identified emergent diagnosis code. If the admission is on an emergency basis, but billed with a non-emergent diagnosis code, you must submit a copy of the client's chart with a request for an exception to rule. Send chart to:

MAA - DHSQS
Attn: Limitation Extension Coordinator
PO Box 45506
Olympia, WA 98504-5506

Acute Physical Medicine & Rehabilitation (PM&R)

Acute PM&R must be performed in an MAA-approved Acute PM&R facility**. All Acute PM&R stays require prior authorization**. See MAA's Acute PM&R Billing Instructions for program specifics.

Organ Transplants

Organ/bone marrow/peripheral stem cell transplants must be performed in an MAA-approved Center of Excellence (CoE).

MAA reimburses for organ transplants under the RCC method beginning on the date of the transplant surgery. Prior to this date, MAA will reimburse the hospital claim using the DRG method.

Example:

1. Bill the initial part of the stay (up to the transplant) under the DRG method; then
2. Interim bill from the transplant date through discharge under the RCC method. All PAS rules apply to the RCC claim. If the transplant RCC claim exceeds the length of stay, you must request a length of stay extension (see page C.1).

☞ **See next page for list of MAA approved Organ Transplant Centers of Excellence (CoE)**

MAA-Approved Organ Transplant Centers of Excellence (CoE) for Inpatient/Outpatient Hospital Services

Approved Transplant Hospitals	Organ(s)	DRG Group
Children's Hospital & Medical Center/Seattle	Bone Marrow (BMT), Liver, Heart, Kidney	103, 302, 480, 803, 804
Fred Hutchinson Cancer Research Center/Seattle	Bone Marrow (BMT) (autologous, allogenic & syngeneic) Peripheral Stem Cell Transplant (PSC-T)	803, 804
Good Samaritan Hospital Medical/Puyallup	Peripheral Stem Cell Transplant (PSC-T) reinfusion	803, 804
Inland NW Blood Center	Peripheral Stem Cell Transplant (PSC) reinfusion	803, 804
Legacy Good Samaritan Hospital/Portland (Northwest Marrow Transplant Program)	Bone Marrow (BMT) Peripheral Stem Cell Transplant (PSC-T) reinfusion	803, 804
Providence St. Peter Hospital/Olympia	Peripheral Stem Cell Transplant (PSC-T) reinfusion	803, 804
OHSU/Oregon (Oregon Health Sciences University)/Portland **Dorenbacher Children's Hospital NW Marrow Transplant Program (PSC-T only)**	Heart Liver Kidney Bone Marrow (BMT) Peripheral Stem Cell Transplant (PSC-T) reinfusion	103, 302, 480, 803, 804
Sacred Heart Medical Center/Spokane	Kidney Heart Heart/Lung(s) Lung	103, 302, 795
St. Joseph's Hospital/Tacoma	Autologous Bone Marrow Transplant Peripheral Stem Cell Transplant (PSC-T) reinfusion	803, 804

Approved Transplant Hospitals	Organ(s)	DRG Group
Swedish/Seattle	Kidney Peripheral Stem Cell Transplant (PSC-T) reinfusion	302, 803, 804
University of Washington Medical Center/Seattle	Bone Marrow Transplant (BMT) (autologous & allogenic & syngeneic) Peripheral Stem Cell Transplant (PSC-T) reinfusion Heart Heart/Lung(s) Lung Kidney Liver Pancreas Kidney/Pancreas	103, 302, 480, 795, 803, 804, 805
Virginia Mason Hospital/Seattle	Kidney Kidney/Pancreas Bone Marrow Transplant (BMT) (autologous & allogenic & syngeneic) Peripheral Stem Cell Transplant (PSC-T) reinfusion	302, 803, 804, 805

DRG Codes: 103 = Heart, 302 = Kidney, 480 = Liver, 795 = Lung, 803 = Allogeneic Bone Marrow Transplant, 804 = Autologous Bone Marrow Transplant, 805 = Kidney/Pancreas

Unbundling

The table below indicates services that might have been billed by the hospital or an outside provider. It should be noted that the technical component includes any supplies that might be provided by a physician or other professional when the same service is provided outside the hospital. **Bill the excluded services on the appropriate claim form.**

TC = Technical Component
I = Cost of service is included in inpatient rate
N/A = Not Applicable to Inpatient Stays

PC = Professional Component
E = Cost of service is excluded from inpatient rate. Bill excluded services on appropriate claim form.

Service Description	TC	PC	Service Description	TC	PC
Air Transportation[1]	I	N/A	Nurse Anesthetist[2]	I	I
Ambulance[1]	I	N/A	Nurse Practitioner[2]	I	I
Audiology/Speech Pathology[2]	I	I	Oxygen	I	I
Whole Blood	N/A	N/A	Specialized Therapies (PT, OT, ST)	I	I
Blood Administration	I	N/A	Physician Specialties[3]	I	E
Blood Components	E	N/A	Podiatry[3]	I	E
Cabulance[1]	I	N/A	Private Duty Nursing Services	I	I
Certified Registered Nurse[2] (Does not include Certified Registered Nurse Anesthetist)	I	I*	Prosthetic/Orthotics (except joints)	I	I
Hearing Aids	E	N/A	Psychiatrist[3]	I	E
Implants (Joints, Tissue, Pacemakers)	I	N/A	Psychology[2]	I	I
Inhalation/Respiratory Therapy	I	I	Radiologist[3]	I	E
Laboratory[3]	I	E	Take-home supplies, equipment, drugs	N/A	N/A
Midwife[2]	I	I			

1 Excluded when transportation occurs 1) before admission, or 2) after discharge or transfer out of that hospital. When the patient is transported as a part of the inpatient services, bill under revenue codes 54X.

2 If independent practitioner bills separately, only the technical component is included in the hospital reimbursement. The practitioner will be reimbursed for the professional component. If the practitioner is employed by the hospital, both the technical and professional components may be included in both the cost and charges for the revenue code where the service is provided.

3 Physician's professional components must be billed separately.

* RN First Assistant excluded.

Other Noncovered Items

Following are examples of "other" noncovered items for hospitals. If one of these items has a Revenue Code (see Appendix), please put the appropriate code in Form Locator 42 (Revenue Code) and the charge amount in Form Locator 48 (Noncovered Charges). Services not identified by a revenue code should be placed under subcategory, "General Classification."

Bed Scales (if person is ambulatory)
Cafeteria
Circumcision Tray (routine circumcisions)
Crisis Counseling
Crutches (rental only is covered) No instruction
C-Section Set-up (if C-Section not performed)
Entertainment services (e.g., rental of TV, radio, VCRs, etc.
Experimental or investigational medical services & supplies
Father's Pack (not medically necessary)
Food Supplements (except for qualified providers)
Home Health Services
Lab Handling Charges
Medical Photographic Electronic & Video Records
Nonpatient Room Rentals
Operating Room Set-Up (when not utilized)
Oxygen Equipment Set-Up (when not utilized)
Personal Care Items (e.g., slippers, toothbrush, combs)
Additional Personnel Charge (payment is included in budget for salaried hospital employees)
Portable X-ray Charges (portable charge fee is included in fee for procedures)
Psychiatric Day Care
Recreational Therapy
Standby Equipment Charges (for oxygen, anesthesia, and surgery when no actual service is performed)

Routine tests and procedures (e.g., pre-anesthesia chest x-rays, fetal monitoring, etc.) are only covered if medically necessary* and approved by physician.
Take Home Drugs/Supplies
Telephone-Telegraph/Fax
Transportation (provided during hospital stay)

Travel Time
Whole Blood (Administration of blood is covered. These charges must clearly indicate administration fees.)

***Major factors supporting a determination of medical necessity are:**

1. **The procedure or test is specifically ordered by admitting physician or a hospital staff physician having responsibility for the patient where there is no admitting physician; i.e., it is not furnished under the standing orders of a physician.**

2. **The procedure or test is for the diagnosis or treatment of the individual patient's condition.**

3. **The procedure or test does not unnecessarily duplicate the same test performed on an outpatient basis prior to admission or performed in connection with a recent admission.**

Authorization

What is prior authorization?

Prior authorization is MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization and limitation extensions are forms of prior authorization.**

What is expedited prior authorization (EPA)?

EPA is designed to eliminate the need for written authorization. MAA establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill MAA for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number.** The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see pages D.2-D.5 for codes). Enter the EPA number on the billing form in *form locator 63*, or in the *Authorization* field when billing electronically.

Example: The 9-digit authorization number for a client with the following criteria would be **870000113:**

- Is 31-years old; and
- Has a diagnosis of endometriosis; and
- Has significant findings per laproscopy; and
- Is unresponsive to 3 months of hormones; or
- Unresponsive to cauterization…

870000 = first six digits of all expedited prior authorization numbers;
113 = last three digits of an EPA number indicating that the above criteria is met.

- MAA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

- The billing provider must document in the client's file how the expedited prior authorization criteria was met, and make this information available to MAA on request.

☞ **Expedited Prior Authorization Criteria Coding List on next page**

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria	Code	Criteria

Abdominal Hysterectomy
ICD-9-CM: 68.3-68.4, 68.6, 68.9

101 Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with two or more of the following conditions:

1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months.
2) Documented hct of <30 or hgb <10
3) Documented failure of conservative care i.e.: d&c, laparoscopy, or hormone therapy for at least three months.

102 Diagnosis of **fibroids** for any one of the following indications in a client 30 years of age or older:

1) Myomata associated with uterus greater than 12 weeks or 10cm in size
2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct <30 or hgb <10
3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.

103 Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following:

1) Significant findings per laproscope and
2) Unresponsiveness to 3 months of hormone therapy or cauterization.

104 Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics

Vaginal Hysterectomy
ICD-9-CM: 68.5-68.59, 68.7, 68.9

111 Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with two or more of the following conditions:

1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months.
2) Documented hct of less than 30 or hgb less than 10.
3) Documentation of failure of conservative care i.e.: d&c, laparoscopy, or hormone therapy for at least three months.

112 Diagnosis of **fibroids** for any one of the following indications in a client 30 years of age or older:

1) Myomata associated with uterus greater than 12 weeks or 10cm in size
2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct less than 30 or hgb less than 10
3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.

113 Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following:

1) Significant findings per laproscope; and
2) Unresponsiveness to 3 months of hormone therapy or cauterization.

114 Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

Code	Criteria

115 Diagnosis of **symptomatic pelvic relaxation** (in a client 30 years of age or older) with a 3rd degree or greater uterine prolapse (at or to vaginal introitus).

Bladder Neck Suspension

ICD-9-CM: 57.89, 59.3-59.79

201 Diagnosis of **stress urinary incontinence** with all of the following:

1) Documented urinary leakage severe enough to cause the client to be pad dependent; and
2) Surgically sterile or past child bearing years; and
3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; and
4) Urodynamics showing loss of ureterovescical angle or physical exam showing weak bladder neck and
5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery.

Hysterectomy With Colopourethrocystopexy

ICD-9-CM: 57.89 or 59.3-59.79 **and** 68.4 or 68.5

221 Diagnosis of **Abnormal uterine bleeding and Stress Urinary Incontinence**-meeting criteria 101 or 111 and 201 as above.

222 Diagnosis of **Fibroids and Stress Urinary Incontinence**-meeting criteria 102 or 112 and 201 as above.

223 Diagnosis of **Symptomatic Endometriosis and Stress Urinary Incontinence**-meeting criteria 103 or 113 and 201 as above.

224 Diagnosis of **Chronic Pelvic Inflammatory Disease and Stress Urinary Incontinence** - meeting criteria 104 and 114 as above.

225 Diagnosis of **Symptomatic Pelvic Relaxation and Stress Urinary Incontinence -** meeting criteria 115 and 201 as above.

226 **Hysterectomy not requiring authorization** (see page 6) and **Stress Urinary Incontinence** meeting criteria 201 previously listed.

Other Hysterectomies and/or Bladder Repairs With Diagnosis Of 625.6 Or 788.3

ICD-9-CM: 57.89, 59.3-59.79, 68.3-68.7, 68.9

230 Hysterectomies and/or bladder repairs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Reduction Mammoplasties/ Mastectomy For Gynecomastia

ICD-9-CM: 85.3-85.36, 85.41-85.42

241 Diagnosis for **hypertrophy of the breast** with:

1) Photographs in client's chart, and
2) Documented medical necessity including:
   a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, and
   b) Conservative treatment not effective; and
3) Abnormally large breasts in relation to body size with shoulder grooves, and
4) Within 20% of ideal body weight, and
5) Verification of minimum removal of 500 grams of tissue from each breast.

242 Diagnosis for **gynecomastia**:

1) Pictures in clients' chart, and
2) Persistent tenderness and pain, and
3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

Code	Criteria

Other Reduction Mammoplasties/ Mastectomy For Gynecomastia With Diagnosis Of 611.1 Or 611.9

ICD-9-CM: 85.3-85.36, 85.41-85.42

250 Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Medical Admits

401 Diagnosis of **Cellulitis** (681-681.9, 682, 682.2-682.9) in a client that received greater than 30 hours of IV antibiotics during the hospitalization and any one of the following:

1) Incision & drainage during admit, or
2) White Count greater than10 on admit, or
3) Persistence or progression of fever, lymphodenopathy, edema, or erythema after a minimum of 24 hours of outpatient antibiotic treatment.

402 Diagnosis of **Abdominal Pain** (789.0-789.09) in a client with a nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours.

403 Diagnosis of **Dehydration or Electrolyte Imbalances** (276-276.6, 276.8-276.9) in a client with abnormal lab values requiring intravenous electrolyte supplementation, during the hospital stay, for greater than 30 hours.

404 Diagnosis of **Nausea/Vomiting** (536.2; 787.0-787.03) in a client:

1) With a Nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours, or
2) That is unable to tolerate PO and is treated with Intravenous medications, during the hospital stay, for greater than 30 hours

405 Diagnosis of **Gastritis** (535-535.6, 558.9) in a client:

1) With a Nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours, or
2) That is unable to tolerate PO and is treated with Intravenous medications, during the hospital stay, for greater than 30 hours.

406 Diagnosis of **headaches** (784.0**,** 346-346.9) in a client receiving Intravenous DHE, during the hospital stay, for greater than 30 hours.

407 Diagnosis of **chronic pancreatitis** (577.1) in a client:

1) With a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; or
2) That is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.

408 Diagnosis of **back pain** (724.1-724.5, 724.8-724.9, 846.0-847.9) in a client:

1) Failed outpatient treatment; and
2) Continued use of IV pain medication, during the hospital stay, greater than 30 hours; or
3) Continued inability to ambulate after physical therapy intervention greater than 30 hours.

409 Diagnosis of **constipation** (560.3, 560.39, 564-564.9) in a client:

1) Failed outpatient treatment; or
2) Recent abdominal surgery; and
3) Extensive inpatient treatment, during the hospital stay, greater than 30 hours.

Other Medical Admits

420 Medical admits requiring expedited prior authorization and not meeting expedited criteria, but medically necessary for continued stay over 24 hours. Medical

Code	Criteria	Code	Criteria
	necessity must be clearly evident by the documentation in the client's medical record. Diagnosis of **related general symptoms** (780, 780.4, 780.9) Diagnosis of **respiratory abnormality** (786.09) Diagnosis of **malaise and fatigue** (780.7) Diagnosis of **painful respiration** (786.52)		

What are limitation extensions?

Limitation extensions are cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administration Code (WAC).

> ☞ **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request a limitation extension?

You must request MAA-approval in writing.

The request must state all of the following:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date of last dispense;
5. The primary diagnosis code and CPT code or state assigned code; and
6. Client-specific clinical justification for additional services.

Send your written request for a limitation extension to:

Division of Health Services Quality Support
Quality Fee for Service Section
Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Fax (360) 586-2262

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
010X	**All Inclusive Rate**				
0	All-Inclusive Room & Board plus Ancillary	**L**	**N**	**NA**	MAA Approved Long Term Acute Care Providers Only.
1	All-Inclusive Room & Board	**N**	**N**	**NA**	
011X	**Room & Board - Private**				
0	General Classificiation	**SP***	**N**	**NA**	
1	Medical/Surgical/Gyn	**SP**	**N**	**NA**	
2	OB	**SP**	**N**	**NA**	
3	Pediatric	**SP**	**N**	**NA**	
4	Psychiatric	**L/SP**	**N**	**NA**	Distinct Psychiatric Units & Freestanding Psychiatric Hospitals Only.
5	Hospice	**N**	**N**	**NA**	
6	Detoxification	**N**	**N**	**NA**	
7	Oncology	**SP**	**N**	**NA**	
8	Rehabilitation	**N**	**N**	**NA**	
9	Other	**N**	**N**	**NA**	
012X	**Room & Board - Semi-Private 2 Bed**				
0	General Classificiation	**Y***	**N**	**NA**	
1	Medical/Surgical/Gyn	**Y**	**N**	**NA**	
2	OB	**Y**	**N**	**NA**	
3	Pediatric	**Y**	**N**	**NA**	
4	Psychiatric	**L**	**N**	**NA**	Distinct Psychiatric Units & Freestanding Psychiatric Hospitals Only
5	Hospice	**N**	**N**	**NA**	
6	Detoxification	**L**	**N**	**NA**	DASA Providers Only.
7	Oncology	**Y**	**N**	**NA**	
8	Rehabilitation	**L**	**N**	**NA**	MAA approved Acute Physical Medicine & Rehabilitation Providers Only.
9	Other	**L**	**N**	**NA**	Chemically-Using Pregnant (CUP) Women's Program, DASA/MAA Approved Providers Only.

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
013X	**Room & Board - Semi-Private 3-4 Beds**				
0	General Classificiation	**Y***	**N**	**NA**	
1	Medical/Surgical/Gyn	**Y**	**N**	**NA**	
2	OB	**Y**	**N**	**NA**	
3	Pediatric	**Y**	**N**	**NA**	
4	Psychiatric	**L**	**N**	**NA**	Distinct Psychiatric Units & Freestanding Psychiatric Hospitals Only
5	Hospice	**N**	**N**	**NA**	
6	Detoxification	**L**	**N**	**NA**	DASA Providers Only
7	Oncology	**Y**	**N**	**NA**	
8	Rehabilitation	**N**	**N**	**NA**	
9	Other	**N**	**N**	**NA**	
014X	**Room & Board - Private (Deluxe)**				
0	General Classificiation	**Y***	**N**	**NA**	
1	Medical/Surgical/Gyn	**SP**	**N**	**NA**	
2	OB	**SP**	**N**	**NA**	
3	Pediatric	**SP**	**N**	**NA**	
4	Psychiatric	**L/SP**	**N**	**NA**	Distinct Psychiatric Units & Freestanding Psychiatric Hospitals Only
5	Hospice	**N**	**N**	**NA**	
6	Detoxification	**N**	**N**	**NA**	
7	Oncology	**SP**	**N**	**NA**	
8	Rehabilitation	**N**	**N**	**NA**	
9	Other	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
015X	**Room & Board - Ward**				
0	General Classificiation	**L**	**N**	**NA**	Military Hospitals Only.
1	Medical/Surgical/Gyn	**N**	**N**	**NA**	
2	OB	**N**	**N**	**NA**	
3	Pediatric	**N**	**N**	**NA**	
4	Psychiatric	**N**	**N**	**NA**	
5	Hospice	**N**	**N**	**NA**	
6	Detoxification	**L**	**N**	**NA**	DASA Providers Only.
7	Oncology	**N**	**N**	**NA**	
8	Rehabilitation	**N**	**N**	**NA**	
9	Other	**N**	**N**	**NA**	
016X	**Room & Board - Other**				
0	General Classificiation	**L**	**N**	**NA**	Military Hospitals for Subsistence Only.
4	Sterile Environment	**N**	**N**	**NA**	
7	Self Care	**N**	**N**	**NA**	
~~***8***~~	~~***Chemical-Using Pregnant Women Program***~~	~~***L***~~	~~***N***~~	~~***NA***~~	***Discontinued for dates of service on and after June 1, 2003. See Revenue Code 129.***
9	Other	**L**	**N**	**NA**	Administrative Days - paid at state-wide weighted average nursing home rate.
017X	**Nursery**				
0	General Classificiation	**Y***	**N**	**NA**	
1	Newborn - Level I	**Y**	**N**	**NA**	
2	Newborn - Level II	**Y**	**N**	**NA**	
3	Newborn- Level III	**Y**	**N**	**NA**	
4	Newborn - Level IV	**Y**	**N**	**NA**	
9	Other Nursery	**N**	**N**	**NA**	
018X	**Leave of Absence**				
0	General Classificiation	**N**	**N**	**NA**	
1	RESERVED	**NA**	**NA**	**NA**	
2	Patient Convenience	**N**	**N**	**NA**	
3	Therapeutic Leave	**N**	**N**	**NA**	
4	ICF/MR - Any Reason	**N**	**N**	**NA**	
5	Nursing Home (for Hospitalization)	**N**	**N**	**NA**	
9	Other Leave of Absence	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
019X	**Subacute Care**				
0	General Classificiation	**N**	**N**	**NA**	
1	Subacute Care - Level I	**N**	**N**	**NA**	
2	Subacute Care - Level II	**N**	**N**	**NA**	
3	Subacute Care - Level III	**N**	**N**	**NA**	
4	Subacute Care - Level IV	**N**	**N**	**NA**	
9	Other Subacute Care	**N**	**N**	**NA**	
020X	**Intensive Care**				
0	General Classificiation	**Y***	**N**	**NA**	
1	Surgical	**Y**	**N**	**NA**	
2	Medical	**Y**	**N**	**NA**	
3	Pediatric	**Y**	**N**	**NA**	
4	Psychiatric	**L**	**N**	**NA**	Medicare Certified Psychiatric Intensive Care Units
6	Intermediate ICU	**Y**	**N**	**NA**	
7	Burn Care	**Y**	**N**	**NA**	
8	Trauma	**Y**	**N**	**NA**	
9	Other Intensive Care	**N**	**N**	**NA**	
021X	**Coronary Care**				
0	General Classification	**Y**	**N**	**NA**	
1	Myocardial Infarction	**Y**	**N**	**NA**	
2	Pulmonary Care	**Y**	**N**	**NA**	
3	Heart Transplant	**L**	**N**	**NA**	MAA Approved Centers of Excellence
4	Intermediate CCU	**Y**	**N**	**NA**	
9	Other Coronary Care	**N**	**N**	**NA**	
022X	**Special Charges**				
0	General Classification	**N**	**N**	**NA**	
1	Admission Charge	**N**	**N**	**NA**	
2	Technical Support Charge	**N**	**N**	**NA**	
3	U.R. Service Charge	**N**	**N**	**NA**	
4	Late Discharge, Medically Necessary	**N**	**N**	**NA**	
9	Other Special Charges	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
023X	**Incremental Nursing Charge Rate**				
0	General Classification	**N**	**N**	**NA**	
1	Nursery	**N**	**N**	**NA**	
2	OB	**N**	**N**	**NA**	
3	ICU	**N**	**N**	**NA**	
4	CCU	**N**	**N**	**NA**	
5	Hospice	**N**	**N**	**NA**	
9	Other	**N**	**N**	**NA**	
024X	**All Inclusive Ancillary**				
0	General Classification	**N**	**N**	**NA**	
1	Basic	**N**	**N**	**NA**	
2	Comprehensive	**N**	**N**	**NA**	
3	Specialty	**N**	**N**	**NA**	
9	Other All Inclusive Ancillary	**N**	**N**	**NA**	
025X	**Pharmacy (also see 063X, an extension of 025X)**				
0	General Classification	**Y***	**R***	**NR**	
1	Generic Drugs	**Y**	**R**	**NR**	
2	Non-generic Drugs	**Y**	**R**	**NR**	
3	Take Home Drugs	**N**	**N**	**NR**	
4	Drugs Incident to Other Diagnostic Services	**Y**	**R**	**NR**	
5	Drugs Incident to Radiology	**Y**	**R**	**NR**	
6	Experimental Drugs	**N**	**N**	**NR**	
7	Non-prescription	**Y**	**R**	**NR**	
8	IV Solutions	**Y**	**R**	**NR**	
9	Other Pharmacy	**N**	**N**	**NA**	
026X	**IV Therapy**				
0	General Classification	**Y***	**R***	**NR**	
1	Infusion Pump	**Y**	**R**	**O**	
2	IV Therapy/Pharmacy Svcs	**Y**	**R**	**NR**	
3	IV Therapy/Drug/Supply Delivery	**Y**	**R**	**NR**	
4	IV Therapy/Supplies	**Y**	**R**	**NR**	
9	Other IV Therapy	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
027X	**Medical/Surgical Supplies & Devices (also see 062X, an extension of 027X)**				
0	General Classification	Y	R	NR	
1	Non-Sterile Supply	Y	R	NR	
2	Sterile Supply	Y	R	NR	
3	Take Home Supplies	N	N	NA	
4	Prosthetic/Orthotic Devices	N	N	M	
5	Pacemaker	Y	R	NR	
6	Intraocular Lens	Y	R	NR	
7	Oxygen - Take Home	N	N	NR	
8	Other Implant	Y	R	NR	
9	Other Supplies/Devices	N	N	NA	
028X	**Oncology**				
0	General Classification	Y	R	NR	
9	Other Oncology	N	N	NA	
029X	**Durable Medical Equipment (Other Than Renal)**				
0	General Classification	N	N	NA	
1	Rental	N	N	NA	
2	Purchase of New DME	N	N	NA	
3	Purchase of Used DME	N	N	NA	
4	Supplies/Drugs for DME Effectiveness (Home Health Agency only)	N	N	NA	
9	Other Equipment	N	N	NA	
030X	**Laboratory**				
0	General Classification	Y	F	O	
1	Chemistry	Y	F	O	
2	Immunology	Y	F	O	
3	Renal Patient (Home)	N	F	O	
4	Non-Routine Dialysis	Y	F	O	
5	Hematology	Y	F	O	
6	Bacteriology & Microbiology	Y	F	O	
7	Urology	Y	F	O	
9	Other Laboratory	N	N	NA	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
031X	**Laboratory - Pathological**				
0	General Classification	**Y**	**F**	**O**	
1	Cytology	**Y**	**F**	**O**	
2	Histology	**Y**	**F**	**O**	
4	Biopsy	**Y**	**F**	**O**	
9	Other Laboratory Pathological	**N**	**N**	**NA**	
032X	**Radiology - Diagnostic**				
0	General Classification	**Y**	**F**	**O**	
1	Angiocardiography	**Y**	**F**	**O**	
2	Arthrography	**Y**	**F**	**O**	
3	Arteriography	**Y**	**F**	**O**	
4	Chest X-Ray	**Y**	**F**	**O**	
9	Other Radiology - Diagnostic	**N**	**N**	**NA**	
033X	**Radiology - Therapeutic**				
0	General Classification	**Y***	**F**	**O**	
1	Chemotherapy - Injected	**Y**	**F**	**O**	
2	Chemotherapy - Oral	**Y**	**F**	**O**	
3	Radiation Therapy	**Y**	**F**	**O**	
5	Chemotherapy - IV	**Y**	**F**	**O**	
9	Other Radiology - Therapeutic	**N**	**N**	**NA**	
034X	**Nuclear Medicine**				
0	General Classification	**Y***	**F**	**O**	
1	Diagnostic	**Y**	**F**	**O**	
2	Therapeutic	**Y**	**F**	**O**	
9	Other Nuclear Medicine	**N**	**N**	**NA**	
035X	**CT Scan**				
0	General Classification	**Y***	**F**	**O**	
1	Head Scan	**Y**	**F**	**O**	
2	Body Scan	**Y**	**F**	**O**	
9	Other CT Scan	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
036X	**Operating Room Services**				
0	General Classification	**Y**	**R**	**O**	
1	Minor Surgery	**Y**	**R**	**O**	
2	Organ Transplant - Other Than Kidney	**L**	**N**	**NA**	MAA Approved Centers of Excellence
7	Kidney Transplant	**L**	**N**	**NA**	MAA Approved Centers of Excellence
9	Other Operating Room Services	**N**	**N**	**NA**	
037X	**Anesthesia**				
0	General Classification	**Y**	**R**	**NR**	
1	Anesthesia Incident to Radiology	**Y**	**R**	**NR**	
2	Anesthesia Incident to Other Diagnostic Services	**Y**	**R**	**NR**	
4	Acupuncture	**N**	**N**	**NA**	
9	Other Anesthesia	**N**	**N**	**NA**	
038X	**Blood**				
0	General Classification	**N**	**N**	**NA**	
1	Packed Red Cells	**N**	**N**	**NA**	
2	Whole Blood	**N**	**N**	**NA**	
3	Plasma	**N**	**N**	**NA**	
4	Platelets	**N**	**N**	**NA**	
5	Leucocytes	**N**	**N**	**NA**	
6	Other Components	**N**	**N**	**NA**	
7	Other Derivatives (Cryopricipitates)	**N**	**N**	**NA**	
9	Other Blood	**N**	**N**	**NA**	
039X	**Blood and Blood Component Administration, Processing & Storage**				
0	General Classification	**Y**	**R**	**NR**	
1	Administration (e.g., transfusions)	**Y**	**R**	**O**	
9	Other Processing and Storage	**N**	**N**	**NA**	
040X	**Other Imaging Services**				
0	General Classification	**Y**	**F**	**O**	
1	Diagnostic Mammography	**Y**	**F**	**O**	
2	Ultrasound	**Y**	**F**	**O**	
3	Screening Mammography	**N**	**F**	**O**	
4	Positron Emission Tomography	**Y**	**F**	**O**	
9	Other Imaging Services	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
041X	**Respiratory Services**				
0	General Classification	**Y**	**R**	**O**	
2	Inhalation Services	**Y**	**R**	**O**	
3	Hyperbaric Oxygen Therapy	**Y**	**R**	**O**	
9	Other Respiratory Services	**N**	**N**	**NA**	
042X	**Physical Therapy**				
0	General Classification	**Y**	**F**	**O**	
1	Visit Charge	**Y**	**F**	**O**	
2	Hourly Charge	**Y**	**F**	**O**	
3	Group Rate	**Y**	**F**	**O**	
4	Evaluation or Re-evaluation	**Y**	**F**	**O**	
9	Other Physical Therapy	**N**	**N**	**NA**	
043X	**Occupational Therapy**				
0	General Classification	**LD**	**F**	**O**	LD if client is 21 yrs of age or older and not in Acute Physical Medicine & Rehabilitation
1	Visit Charge	**LD**	**F**	**O**	LD if client is 21 yrs of age or older and not in Acute Physical Medicine & Rehabilitation
2	Hourly Charge	**LD**	**F**	**O**	LD if client is 21 yrs of age or older and not in Acute Physical Medicine & Rehabilitation
3	Group Rate	**LD**	**F**	**O**	LD if client is 21 yrs of age or older and not in Acute Physical Medicine & Rehabilitation
4	Evaluation or Re-evaluation	**LD**	**F**	**O**	LD if client is 21 yrs of age or older and not in Acute Physical Medicine & Rehabilitation
9	Other Occupational Therapy	**N**	**N**	**NA**	
	Note: Please see Diagnosis List for Occupational Therapy on page E23.				
044X	**Speech-Language Pathology**				
0	General Classification	**Y**	**F**	**O**	
1	Visit Charge	**Y**	**F**	**O**	
2	Hourly Charge	**Y**	**F**	**O**	
3	Group Rate	**Y**	**F**	**O**	
4	Evaluation or Re-evaluation	**Y**	**F**	**O**	
9	Other Speech-Language Pathology	**N**	**N**	**NA**	
	Note: Please see Grid Legend on page E22.				

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
045X	**Emergency Room**				
0	General Classification	**Y**	**R**	**O**	
1	EMTALA Emergency Medical Screening Svcs	**N**	**N**	**NA**	
2	ER Beyond EMTALA Screening	**N**	**N**	**NA**	
6	Urgent Care	**Y**	**R**	**O**	
9	Other Emergency Room	**N**	**N**	**NA**	
046X	**Pulmonary Function**				
0	General Classification	**Y**	**R**	**O**	
9	Other Pulmonary Function	**N**	**N**	**NA**	
047X	**Audiology**				
0	General Classification	**N**	**F**	**O**	
1	Diagnostic	**N**	**F**	**O**	
2	Treatment	**N**	**F**	**O**	
9	Other Audiology	**N**	**N**	**NA**	
048X	**Cardiology**				
0	General Classification	**Y**	**R**	**O**	
1	Cardiac Cath Lab	**Y**	**R**	**O**	
2	Stress Test	**Y**	**F**	**O**	
3	Echocardiology	**Y**	**F**	**O**	
9	Other Cardiology	**N**	**N**	**NA**	
049X	**Ambulatory Surgical Care**				
0	General Classification	**Y**	**R**	**O**	
9	Other Ambulatory Surgical Care	**N**	**N**	**NA**	
050X	**Outpatient Services**				
0	General Classification	**Y**	**R**	**O**	
9	Other Outpatient Service	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
051X	**Clinic**				
0	General Classification	**N**	**L/R**	**O**	MAA Approved Facilities Only
1	Chronic Pain Center	**L**	**N**	**NA**	MAA Approved Inpatient Pain Programs
2	Dental Clinic	**N**	**L/R**	**O**	MAA Approved Facilities Only
3	Psychiatric Clinic	**N**	**N**	**NA**	
4	OB-GYN Clinic	**N**	**N**	**NA**	
5	Pediatric Clinic	**N**	**N**	**NA**	
6	Urgent Care Clinic	**N**	**N**	**NA**	
7	Family Practice Clinic	**N**	**N**	**NA**	
9	Other Clinic	**N**	**L/R**	**O**	MAA Approved Facilities Only
052X	**Free-Standing Clinic**				
0	General Classification	**N**	**N**	**NA**	
1	Rural Health - Clinic	**N**	**N**	**NA**	
2	Rural Health - Home	**N**	**N**	**NA**	
3	Family Practice Clinic	**N**	**N**	**NA**	
6	Urgent Care Clinic	**N**	**N**	**NA**	
9	Other Free-Standing Clinic	**N**	**N**	**NA**	
053X	**Osteopathic Services**				
0	General Classification	**N**	**N**	**NA**	
1	Osteopathic Services	**N**	**N**	**NA**	
9	Other Osteopathic Services	**N**	**N**	**NA**	
054X	**Ambulance**				
0	General Classification	**N**	**N**	**NA**	
1	Supplies	**N**	**N**	**NA**	
2	Medical Transport	**N**	**N**	**NA**	
3	Heart Mobile	**N**	**N**	**NA**	
4	Oxygen	**N**	**N**	**NA**	
5	Air Ambulance	**N**	**N**	**NA**	
6	Neonatal Ambulance Services	**L**	**N**	**NA**	MAA Approved Neonatal Transport Teams.
7	Pharmacy	**N**	**N**	**NA**	
8	Telephone Transmission EKG	**N**	**N**	**NA**	
9	Other Ambulance	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
055X	**Skilled Nursing**				
0	General Classification	**N**	**N**	**NA**	
1	Visit Charge	**N**	**N**	**NA**	
2	Hourly Charge	**N**	**N**	**NA**	
9	Other Skilled Nursing	**N**	**N**	**NA**	
056X	**Medical Social Services**				
0	General Classification	**N**	**N**	**NA**	
1	Visit Charge	**N**	**N**	**NA**	
2	Hourly Charge	**N**	**N**	**NA**	
9	Other Medical Social Services	**N**	**N**	**NA**	
057X	**Home Health - Home Health Aide**				
0	General Classification	**N**	**N**	**NA**	
1	Visit Charge	**N**	**N**	**NA**	
2	Hourly Charge	**N**	**N**	**NA**	
9	Other Home Health Aide	**N**	**N**	**NA**	
058X	**Home Health - Other Visits**				
0	General Classification	**N**	**N**	**NA**	
1	Visit Charge	**N**	**N**	**NA**	
2	Hourly Charge	**N**	**N**	**NA**	
9	Other Home Health Visit	**N**	**N**	**NA**	
059X	**Home Health - Units of Service**				
0	General Classification	**N**	**N**	**NA**	
9	Home Health Other Units	**N**	**N**	**NA**	
060X	**Home Health - Oxygen**				
0	General Classification	**N**	**N**	**NA**	
1	Oxygen - State/Equip/Suppl/or Cont	**N**	**N**	**NA**	
2	Oxygen - State/Equip/Suppl/Under 1 LPM	**N**	**N**	**NA**	
3	Oxygen - State/Equip/Over 4 LPM	**N**	**N**	**NA**	
4	Oxygen - Portable Add-on	**N**	**N**	**NA**	
9	Other Oxygen	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
061X	**Magnetic Resonance Technology (MRT)**				
0	General Classification	**Y**	**F**	**O**	
1	MRI - Brain (Including Brainstem)	**Y**	**F**	**O**	
2	MRI - Spinal Cord (Including Spine)	**Y**	**F**	**O**	
3	RESERVED	**NA**	**NA**	**NA**	
4	MRI - Other	**Y**	**F**	**O**	
5	MRA - Head and Neck	**Y**	**F**	**O**	
6	MRA - Lower Extremities	**Y**	**F**	**O**	
7	RESERVED	**NA**	**NA**	**NA**	
8	MRA - Other	**N**	**F**	**O**	
9	Other MRT	**N**	**N**	**NA**	
062X	**Medical/Surgical Supplies - Extension of 027X**				
1	Supplies Incident to Radiology	**Y**	**F**	**M**	
2	Supplies Incident to Other Diagnostic Services	**Y**	**F**	**M**	
3	Surgical Dressings	**Y**	**R**	**O**	
4	FDA Investigational Devices	**N**	**N**	**NA**	
063X	**Pharmacy - Extension of 025X**				
0	RESERVED	**NA**	**NA**	**NA**	
1	Single Source Drug	**Y**	**R**	**M**	
2	Multiple Source Drug	**Y**	**R**	**M**	
3	Restrictive Prescription	**Y**	**R**	**M**	
4	Erythropoietin (EPO) less than 10,000 units	**Y**	**R**	**O**	
5	Erythropoietin (EPO) 10,000 or more units	**Y**	**R**	**O**	
6	Drugs Requiring Detailed Coding	**Y**	**R**	**O**	
7	Self-administrable Drugs	**Y**	**R**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
064X	**Home IV Therapy Services**				
0	General Classification	**N**	**N**	**NA**	
1	Non-Routine Nursing, Central Line	**N**	**N**	**NA**	
2	IV Site Care, Central Line	**N**	**N**	**NA**	
3	IV Start/Change, Pheripheral Line	**N**	**N**	**NA**	
4	Non-Routine Nursing, Peripheral Line	**N**	**N**	**NA**	
5	Training, Patient/Caregiver, Central Line	**N**	**N**	**NA**	
6	Training, Disabled Patient, Central Line	**N**	**N**	**NA**	
7	Training, Patient/Caregiver, Peripheral Line	**N**	**N**	**NA**	
8	Training, Disabled Patient, Peripheral Line	**N**	**N**	**NA**	
9	Other IV Therapy Services	**N**	**N**	**NA**	
065X	**Hospice Services**				
0	General Classification	**N**	**N**	**NA**	
1	Routine Home Care	**N**	**N**	**NA**	
2	Continuous Home Care	**N**	**N**	**NA**	
3	RESERVED ***(Nursing Facility Room&Board)***	**NA**	**NA**	**NA**	
4	RESERVED	**NA**	**NA**	**NA**	
5	Inpatient Respite Care	**N**	**N**	**NA**	
6	General Inpatient Care (Non-Respite)	**N**	**N**	**NA**	
7	Physician Services	**N**	**N**	**NA**	
9	Other Hospice Services	**N**	**N**	**NA**	
066X	**Respite Care**				
0	General Classification	**N**	**N**	**NA**	
1	Hourly Charge/Nursing	**N**	**N**	**NA**	
2	Hourly Charge/Aide/Homemaker/Companion	**N**	**N**	**NA**	
3	Daily Respite Charge	**N**	**N**	**NA**	
9	Other Respite Care	**N**	**N**	**NA**	
067X	**Outpatient Special Residence Charges**				
0	General Classification	**N**	**N**	**NA**	
1	Hospital Based	**N**	**N**	**NA**	
2	Contracted	**N**	**N**	**NA**	
9	Other Special Residence Charge	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
068X	**Trauma Response**				
0	NOT USED	**NA**	**NA**	**NA**	
1	Level I	**N**	**N**	**NA**	
2	Level II	**N**	**N**	**NA**	
3	Level III	**N**	**N**	**NA**	
4	Level IV	**N**	**N**	**NA**	
9	Other Trauma Response	**N**	**N**	**NA**	
069X	**Not Assigned**				
070X	**Cast Room**				
0	General Classification	**Y**	**R**	**NR**	
9	Other Cast Room	**N**	**N**	**NA**	
071X	**Recovery Room**				
0	General Classification	**Y**	**R**	**NR**	
9	Other Recovery Room	**N**	**N**	**NA**	
072X	**Labor Room/Delivery**				
0	General Classification	**Y**	**R**	**NR**	
1	Labor	**Y**	**R**	**NR**	
2	Delivery	**Y**	**R**	**O**	
3	Circumcision	**N**	**N**	**NA**	
4	Birthing Center	**Y**	**R**	**O**	
9	Other Labor/Delivery	**N**	**N**	**NA**	
073X	**EKG/ECG (Electrocardiogram)**				
0	General Classification	**Y**	**F**	**O**	
1	Holter Monitor	**Y**	**F**	**O**	
2	Telemetry	**Y**	**F**	**M**	
9	Other EKG/ECG	**N**	**N**	**NA**	
074X	**EEG (Electroencephalogram)**				
0	General Classification	**Y**	**F**	**O**	
9	Other EEG	**N**	**N**	**NA**	
075X	**Gastro-Intestinal Services**				
0	General Classification	**Y**	**R**	**O**	
9	Other Gastro-Intestinal	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
076X	**Treatment/Observation Room**				
0	General Classification	**Y**	**R**	**O**	
1	Treatment Room	**Y**	**R**	**O**	
2	Observation Room	**Y**	**R**	**NR**	
9	Other Treatment/Observation Room	**N**	**N**	**NA**	
077X	**Preventive Care Services**				
0	General Classification	**N**	**N**	**NA**	
1	Vaccine Administration	**N**	**N**	**NA**	
9	Other Preventive Care Services	**N**	**N**	**NA**	
078X	**Telemedicine**				
0	General Classification	**N**	**N**	**NA**	
9	Other Telemedicine	**N**	**F**	**NA**	
079X	**Lithotripsy**				
0	General Classification	**Y**	**R**	**O**	
9	Other Lithotripsy	**N**	**N**	**NA**	
080X	**Inpatient Renal Dialysis**				
0	General Classification	**Y**	**NA**	**NA**	
1	Inpatient Hemodialysis	**Y**	**NA**	**NA**	
2	Inpatient Peritoneal (Non-CAPD)	**Y**	**NA**	**NA**	
3	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	**Y**	**NA**	**NA**	
4	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	**Y**	**NA**	**NA**	
9	Other Inpatient Dialysis	**N**	**NA**	**NA**	
081X	**Acquisition of Body Components**				
0	General Classification	**Y**	**R**	**NR**	
1	Living Donor	**Y**	**R**	**O**	
2	Cadaver Donor	**Y**	**R**	**O**	
3	Unknown Donor	**N**	**N**	**NA**	
4	Unsuccessful Organ Search - Donor Bank Charges	**N**	**N**	**NA**	
9	Other Donor	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
082X	**Hemodialysis - Outpatient or Home**				
0	General Classification	**N**	**R**	**O**	
1	Hemodialysis/Composite or Other Rate	**N**	**N**	**NA**	
2	Home Supplies	**N**	**N**	**NA**	
3	Home Equipment	**N**	**N**	**NA**	
4	Maintenance/100% (Home)	**N**	**N**	**NA**	
5	Support Services (Home)	**N**	**N**	**NA**	
9	Other Outpatient Hemodialysis (Home)	**N**	**N**	**NA**	
083X	**Peritoneal Dialysis - Outpatient or Home**				
0	General Classification	**N**	**R**	**O**	
1	Peritoneal /Composite or Other Rate	**N**	**N**	**NA**	
2	Home Supplies	**N**	**N**	**NA**	
3	Home Equipment	**N**	**N**	**NA**	
4	Maintenance/100% (Home)	**N**	**N**	**NA**	
5	Support Services (Home)	**N**	**N**	**NA**	
9	Other Outpatient Peritoneal Dialysis (Home)	**N**	**N**	**NA**	
084X	**Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home**				
0	General Classification	**N**	**R**	**O**	
1	CAPD/Composite or Other Rate	**N**	**N**	**NA**	
2	Home Supplies	**N**	**N**	**NA**	
3	Home Equipment	**N**	**N**	**NA**	
4	Maintenance/100% (Home)	**N**	**N**	**NA**	
5	Support Services (Home)	**N**	**N**	**NA**	
9	Other Outpatient CAPD (Home)	**N**	**N**	**NA**	
085X	**Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home**				
0	General Classification	**N**	**R**	**O**	
1	CCPD/Composite or Other Rate	**N**	**N**	**NA**	
2	Home Supplies	**N**	**N**	**NA**	
3	Home Equipment	**N**	**N**	**NA**	
4	Maintenance/100%	**N**	**N**	**NA**	
5	Support Services	**N**	**N**	**NA**	
9	Other Outpatient CCPD	**N**	**N**	**NA**	
086X	**Reserved for Dialysis (National Assignment)**	**NA**	**NA**	**NA**	
087X	**Reserved for Dialysis (National Assignment)**	**NA**	**NA**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
088X	**Miscellaneous Dialysis**				
0	General Classification	**N**	**R**	**O**	
1	Ultrafiltration	**Y**	**R**	**O**	
2	Home Dialysis Aid Visit	**N**	**N**	**NA**	
9	Other Miscellaneous Dialysis	**N**	**N**	**NA**	
089X	**Reserved for National Assignment**				
~~***0***~~	~~***General Classification***~~	~~***Y***~~	~~***Y***~~	~~**NA**~~	No longer reimbursed for dates of service on or after 7/1/03.
~~***1***~~	~~***Bone***~~	~~***Y***~~	~~***Y***~~	~~**NA**~~	No longer reimbursed for dates of service on or after 7/1/03.
~~***2***~~	~~***Organ (Other than Kidney)***~~	~~***Y***~~	~~***Y***~~	~~**NA**~~	No longer reimbursed for dates of service on or after 7/1/03.
~~***3***~~	~~***Skin***~~	~~***Y***~~	~~***Y***~~	~~**NA**~~	No longer reimbursed for dates of service on or after 7/1/03.
~~***7***~~	~~***Peripheral Blood Stem Cell Transplant - Harvesting***~~	~~***Y***~~	~~***Y***~~	~~**NA**~~	No longer reimbursed for dates of service on or after 7/1/03.
~~***8***~~	~~***Peripheral Blood Stem Cell Transplant - Reinfusion***~~	~~***Y***~~	~~***Y***~~	~~**NA**~~	No longer reimbursed for dates of service on or after 7/1/03.
~~***9***~~	~~***Other Donor Bank***~~	~~***N***~~	~~***N***~~	~~**NA**~~	No longer reimbursed for dates of service on or after 7/1/03.
090X	**Psychiatric/Psychological Treatments**				
0	General Classification	**N**	**N**	**NA**	
1	Electroshock Treatment	**L**	**R**	**O**	Distinct Psychiatric Units & Free Standing Psychiatric Hospitals only.
2	Milieu Therapy	**N**	**N**	**NA**	
3	Play Therapy	**N**	**N**	**NA**	
4	Activity Therapy	**N**	**N**	**NA**	
9	Other Psychiatric/Psychological Treatment	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
091X	**Psychiatric/Psychological Services**				
0	General Classification	**N**	**N**	**NA**	
1	Rehabilitation	**L**	**N**	**NA**	Limited to MAA approved Acute Physical Medicine & Rehabilitation providers
2	Partial Hospitalization - Less Intensive	**N**	**N**	**NA**	
3	Partial Hospitalization - Intensive	**N**	**N**	**NA**	
4	Individual Therapy	**N**	**N**	**NA**	
5	Group Therapy	**N**	**N**	**NA**	
6	Family Therapy	**N**	**N**	**NA**	
7	Bio Feedback	**N**	**N**	**NA**	
8	Testing	**N**	**N**	**NA**	
9	Other Psychiatric/Psychological	**N**	**N**	**NA**	
092X	**Other Diagnostic Services**				
0	General Classification	**N**	**N**	**NA**	
1	Peripheral Vascular Lab	**Y**	**F**	**O**	
2	Electromyelogram	**Y**	**F**	**O**	
3	Pap Smear	**N**	**F**	**O**	
4	Allergy Test	**N**	**N**	**O**	
5	Pregnancy Test	**Y**	**F**	**O**	
9	Other Diagnostic Service	**N**	**N**	**NA**	
093X	**Medical Rehabilitation Day Program**				
1	Half Day	**N**	**N**	**NA**	
2	Full Day	**N**	**N**	**NA**	
094X	**Other Therapeutic Services (Also see 095X, an extension of 094X)**				
0	General Classification	**N**	**N**	**NA**	
1	Recreational Therapy	**N**	**N**	**NA**	
2	Education/Training ***(Diabetic Education)***	**N**	**L/R**	**NR**	Department of Health Approved Diabetic Education Providers Only.
3	Cardiac Rehabilitation	**N**	**N**	**NA**	
4	Drug Rehabilitation	**N**	**N**	**NA**	
5	Alcohol Rehabilitation	**N**	**N**	**NA**	
6	Complex Medical Equipment - Routine	**N**	**N**	**NA**	
7	Complex Medical Equipment - Ancillary	**N**	**N**	**NA**	
9	Other Therapeutic Services	**N**	**L/F**	**O**	MAA Approved Weight Loss Providerrs

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
095X	**Other Therapeutic Services-Extension of 094X**				
0	RESERVED	**NA**	**NA**	**NA**	
1	Athletic Training	**N**	**N**	**NA**	
2	Kinesiotherapy	**N**	**N**	**NA**	
096X	**Professional Fees (also see 097X and 098X)**				
0	General Classification	**N**	**N**	**NA**	
1	Psychiatric	**N**	**N**	**NA**	
2	Ophthalmology	**N**	**N**	**NA**	
3	Anesthesiologist (MD)	**N**	**N**	**NA**	
4	Anesthetist (CRNA)	**N**	**N**	**NA**	
9	Other Professional Fee	**N**	**N**	**NA**	
097X	**Professional Fees (Extension of 096X)**				
1	Laboratory	**N**	**N**	**NA**	
2	Radiology - Diagnostic	**N**	**N**	**NA**	
3	Radiology - Therapeutic	**N**	**N**	**NA**	
4	Radiology - Nuclear Medicine	**N**	**N**	**NA**	
5	Operating Room	**N**	**N**	**NA**	
6	Respiratory Therapy	**N**	**N**	**NA**	
7	Physical Therapy	**N**	**N**	**NA**	
8	Occupational Therapy	**N**	**N**	**NA**	
9	Speech Pathology	**N**	**N**	**NA**	
098X	**Professional Fees (Extension of 096X and 097X)**				
1	Emergency Room	**N**	**N**	**NA**	
2	Outpatient Services	**N**	**N**	**NA**	
3	Clinic	**N**	**N**	**NA**	
4	Medical Social Services	**N**	**N**	**NA**	
5	EKG	**N**	**N**	**NA**	
6	EEG	**N**	**N**	**NA**	
7	Hospital Visit	**N**	**N**	**NA**	
8	Consultation	**N**	**N**	**NA**	
9	Private Duty Nurse	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

REVENUE CODES FOR INPATIENT AND OUTPATIENT BILLING

(effective for dates of service on and after 01/01/04)

REV CODE	DESCRIPTION	IP	OP	OP PROC CODE REQ	COMMENTS
099X	**Patient Convenience Items**				
0	General Classification	**N**	**N**	**NA**	
1	Cafeteria/Guest Tray	**N**	**N**	**NA**	
2	Private Linen Service	**N**	**N**	**NA**	
3	Telephone/Telegraph	**N**	**N**	**NA**	
4	TV/Radio	**N**	**N**	**NA**	
5	Nonpatient Room Rentals	**N**	**N**	**NA**	
6	Late Discharge Charge	**N**	**N**	**NA**	
7	Admission Kits	**N**	**N**	**NA**	
8	Beauty Shop/Barber	**N**	**N**	**NA**	
9	Other Patient Convenience Items	**N**	**N**	**NA**	

Note: Please see Grid Legend on page E22.

Grid is not intended to be a reflection of all policies related to these codes. Please see appropriate billing instructions and Washington Administrative Code (WAC) for complete policy.

Grid Legend

*	=	Currently covered, MAA anticipates requiring more specific revenue codes on or about Jan 2004.
DASA	=	Division of Alcohol and Substance Abuse
F	=	Services routinely reimbursed using MAA's outpatient hospital fee schedule. Revenue code still required on claim line.
IP	=	Inpatient Hospital
L	=	Limited to providers approved by the department to perform specific services
LD	=	Limited by diagnosis, refer to comments or list on page E22
M	=	MAA requires Current Procedural Terminology(CPT) or Healthcare Common Procedure Coding System (HCPCS) on claim line.
MAA	=	Medical Assistance Administration
N	=	Not covered by MAA
NA	=	Not applicable
NR	=	CPT/HCPCS not required
O	=	CPT/HCPCS coding required in preparation for OPPS. Revenue codes still required on claim line. Services will be reimbursed using the current published methodology.
OP	=	Outpatient Hospital
OPPS	=	Outpatient Prospective Payment System
PROC	=	Procedure code
R	=	Service routinely reimbursed using hospital outpatient rate
REQ	=	Required
REV	=	Revenue
SP	=	Paid at semi-private rate
Y	=	Services routinely covered

Diagnosis Code List for Inpatient Occupational Therapy:

342 - 342.9 - Hemiplegia & Hemiparesis

344 - 344.9 - Other Paralytic Syndromes

430 - 438.9 - Cerebrovascular Disease

800 - 804.9 - Fracture of the Skull

850.3 - 850.5 - Concussion

851 - 851.9 - Cerebral Laceration & Contusion

852 - 852.5 - Subarachnoid, Subdural & Extradural Hemorrhage Following Injury

853 - 853.1 - Other & Unspecified Intracranial Hemorrhage Following Injury

854 - 854.1 - Intracranial Injury of Other & Unspecified Nature

905.0 - Late Effect of Fracture of Skull & Face Bone

907.0 - Late Effect of Intracranial Injury Without Mention of Skull Fracture

907.1 - Late Effect of Injury to Cranial Nerve

940-949.5 - Burns

This page intentionally left blank...

General Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- Providers must submit initial claims and adjust prior claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- Providers must submit their claim to MAA and have an Internal Control Number (ICN) assigned by MAA within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed certification[1] criteria.

  ☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive certification[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

Managed care clients

Clients with a plan identifier in the HMO column on their MAID card are enrolled in a Healthy Options managed care plan and **are eligible** for all inpatient hospital services through their designated plan. The plan's telephone number is located in the bottom right hand corner of the client's MAID card. The client's PCP must authorize services prior to rendering them, **except for emergency services**.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients enter the following on the UB-92 claim form:

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s) in form locator 83a. If the client is enrolled with a PCCM and the PCCM referral number is not in form locator 83a when you bill MAA, the claim will be denied; and

- Enter the name of the referring physician's or Primary Care Case Manager's (PCCM) in form locator 83b.

  ☞ **Note:** Newborns of PCCM clients are considered fee-for-service until a PCCM has been chosen for them. All services should be billed to MAA.

Claims for Babies

For services provided to a baby who has not yet received his/her Medical Assistance IDentification (MAID) card, bill MAA using the parent's PIC.

- Indicate J0 (zero) in form locator 32 - Occurrence Code Field; and
- Enter the baby's birthdate in form locator 32 – Occurrence Date Field.

Identify each baby separately when using a parent's PIC for babies who are twins, triplets, etc., **(e.g., twin A, twin B in form locator 84)**. Use a **separate claim form** for each baby.

Services for mothers should also be billed on separate UB-92 claim forms.

How do I bill for clients eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance and the services are covered by Medicare, **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Effective April 1, 1999, payments for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service (whether normally DRG or RCC reimbursed) had the service been reimbursed under the ratio of costs-to-charges (RCC) payment method.

When billing Medicare:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the MAID card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing.
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

NOTE:

- ✓ **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Medicare Part B – This does not apply to Inpatient Hospital Services.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their MAID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If Medicaid covers the service and Medicare does not cover the service, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare does not** cover the service,
MAA will not reimburse the service.

General Provider Requirements **[Refer to WAC 388-502-0020]**

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Chief complaint or reason for each visit;
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, <u>for six years from the date of service</u> or longer if required specifically by federal or state law or regulation.

Additional Requirements – Specific to Hospitals

- ✓ Consultation reports;
- ✓ Discharge summary;
- ✓ History & physical;
- ✓ Operative reports;
- ✓ Pathology;
- ✓ Progress notes; and
- ✓ Treatment orders.

Hysterectomy Procedures

- Hysterectomy will be authorized only for medical reasons unrelated to sterilization.
- Authorization is not required for clients over the age of 45.
- Federal regulations prohibit claims from being processed for hysterectomy procedures until a completed consent form is received. In order to comply with this requirement, surgeons, anesthesiologists, and assistant surgeons must attach a copy of a completed consent form to their claims.
- Claims for a hysterectomy procedure without consent forms will be denied.
- A claim with an incomplete consent form will be returned or denied.
- The claim and completed consent form are to be submitted to the:

DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248

- A completed sample consent form follows this page. A blank consent form which may be photocopied for your use follows the sample. Any consent form may be used, but it must contain all the consent requirements listed below:

  - ✓ Client's name
  - ✓ Reason for hysterectomy
  - ✓ Physician's signature
  - ✓ Client's signature

This is a blank page.

SAMPLE HYSTERECTOMY FORM...TO BE INCLUDED

BLANK BACK PAGE

BLANK
HYSTERECTOMY CONSENT FORM

This is a blank page.

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

If a client is not eligible for the entire hospital stay, bill only dates of service for which the client is eligible.

When billing electronically, indicate claim type "S" for RCC.

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital

Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's medical assistance ID card.

13. **Patient's Address** - Enter the client's address. (MMDDYYYY)

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex (M or F).

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour which the patient was admitted for inpatient care. Use the appropriate two-digit code listed in the following list:

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a skilled nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care. (Use **Admission Hour** list.)

22. **Patient Status** - Enter one of the following codes to represent the disposition of the recipient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Discharged/transferred to another short-term general hospital for inpatient care
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to an intermediate care facility (ICF)
05 = Discharged/transferred to another type of institution for inpatient care
06 = Discharged/transferred to home under care of home health service organization
07 = Left against medical advice or discontinued care
20 = Expired
30 = Still patient

32-35. Occurrence Codes and Dates - Beginning in form locator 32, enter the appropriate occurrence code.

Following are some common examples, please refer to your UB-92 manual for a complete listing:

J0 =	Baby on mom's PIC
01 =	Auto Accident
02 =	Auto Accident/No Fault Insurance Involved
03 =	Accident/Tort Liability
04 =	Accident/Employment Related
05 =	Other Accident
06 =	Crime Victims
X1 =	Trauma Condition Code

38. Responsible Party Name and Address – Enter the name and address of the party responsible for the bill.

39-41. Value Codes and Amounts – Enter one of the following, as appropriate:

45 = Accident Hour (use the chart listed next to form locator 18 for admission hours)

80 = Newborn's birthweight in gram

42. Revenue Code - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. Revenue or Procedure Description - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. HCPCS/Rates - Enter the accommodation rate for inpatient bills.

46. Units of Service - Enter the quantity of services listed by revenue codes.

47. Total Charges - Enter charges pertaining to the related revenue code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. Noncovered - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. Payer Identification: A/B/C - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51A. **Provider Number** - Enter the hospital provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

54. **Prior Payments: A/B/C** - Enter the amount due or received from other insurance **or enter patient's spenddown, if applicable**.

55. **Estimated Amount Due: A/B/C** - The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

58. **Insured's Name: A/B/C** – Enter the name of the individual in whose name the insurance is carried.

60. **Cert-SSN-HIC-ID NO.** - Enter the MAA Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current monthly MAID card and consists of:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters/characters of the last name. (If fewer than five letters in the last name, use spaces before adding the tiebreaker. Or in the case of a hypenated name, use hypens.)
d. An alpha or numeric character (tiebreaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

64. **Employment Status Code** – Enter the code used to define the employment status of the individual identified in Form Locator 58.

1 =Employed full time
2 =Employed part time
3 =Not employed
4 =Self-employed
5 =Retired
6 =Active Military
9 =Unknown

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **Admitting Diagnosis** – Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

Sample UB-92 Claim Form

How to Complete the UB-92 Medicare Part A/Medicaid Crossover Claim Form

(Use these instructions when submitting claims for dual-eligible [Medicare/Medicaid] clients.)

You must submit the Medicare/Medicaid billing form UB-92 to:

Division of Program Support
PO Box 9246
Olympia WA 98507-9246

along with a copy of your Explanation of Medicare Benefits (EOMB).

The numbered boxes on the claim form are referred to as ***form locators***. *Only form locators that pertain to MAA are addressed here.*

Complete the UB-92 claim form in the usual manner required by MAA; however, there are form locators that need specific information indicated in order to process your claim. See the following instructions and claim form samples.

FORM LOCATOR, NAME AND INSTRUCTION FOR COMPLETION

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital

Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Assistance IDentification (MAID) card.

13. **Patient's Address** - Enter the client's address. (MMDDYYYY)

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex (M or F).

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for inpatient care. Use the appropriate two-digit code listed in the following list:

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a skilled nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care. (Use **Admission Hour** list.)

22. **Patient Status** - Enter one of the following codes to represent the disposition of the recipient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Discharged/transferred to another short-term general hospital for inpatient care
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to an intermediate care facility (ICF)
05 = Discharged/transferred to another type of institution for inpatient care
06 = Discharged/transferred to home under care of home health service organization
07 = Left against medical advice or discontinued care
20 = Expired
30 = Still patient

32-35. Occurrence Codes and Dates - Beginning in form locator 32, enter the appropriate occurrence code.

Following are some common examples, please refer to your UB-92 manual for a complete listing:

J0 = Baby on mom's PIC
01 = Auto Accident
02 = Auto Accident/No Fault Insurance Involved
03 = Accident/Tort Liability
04 = Accident/Employment Related
05 = Other Accident
06 = Crime Victims
X1 = Trauma Condition Code

38. Responsible Party Name and Address – Enter the name and address of the party responsible for the bill.

39-41. Value Codes and Amounts

39A: Deductible: Enter the code *A1*, and the deductible as reported on your EOMB.

40A: Coinsurance: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: Encounter Units: Enter the encounter units Medicare paid, as reported on EOMB.

41A: Medicare Payment: Enter the payment by Medicare as reported on your EOMB.

42. Revenue Code - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. Revenue or Procedure Description - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. HCPCS/Rates - Enter the accommodation rate for inpatient bills.

46. Units of Service - Enter the quantity of services listed by revenue codes.

47. Total Charges - Enter charges pertaining to the related revenue code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. Noncovered - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. Payer Identification: A/B/C - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51A. **Provider Number** - Enter the hospital provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

54. **Prior Payments: A/B/C** - Enter the amount due or received from other insurance **or enter patient's spenddown, if applicable**.

55. **Estimated Amount Due: A/B/C** - The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

58. **Insured's Name: A/B/C** – Enter the name of the individual in whose name the insurance is carried.

60. **Cert-SSN-HIC-ID NO.** - Enter the MAA Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current monthly MAID card and consists of:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters/characters of the last name. (If fewer than five letters in the last name, use spaces before adding the tiebreaker. Or in the case of a hypenated name, use hypens.)
d. An alpha or numeric character (tiebreaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

63. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

64. **Employment Status Code** – Enter the code used to define the employment status of the individual identified in Form Locator 58.

1 = Employed full time
2 = Employed part time
3 = Not employed
4 = Self-employed
5 = Retired
6 = Active Military
9 = Unknown

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **Admitting Diagnosis** – Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

Sample Medicare Part B/Medicaid Crossover UB-92 Claim Form